

MARYLAND STATE DEPARTMENT OF HEALTH

12312

12335

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

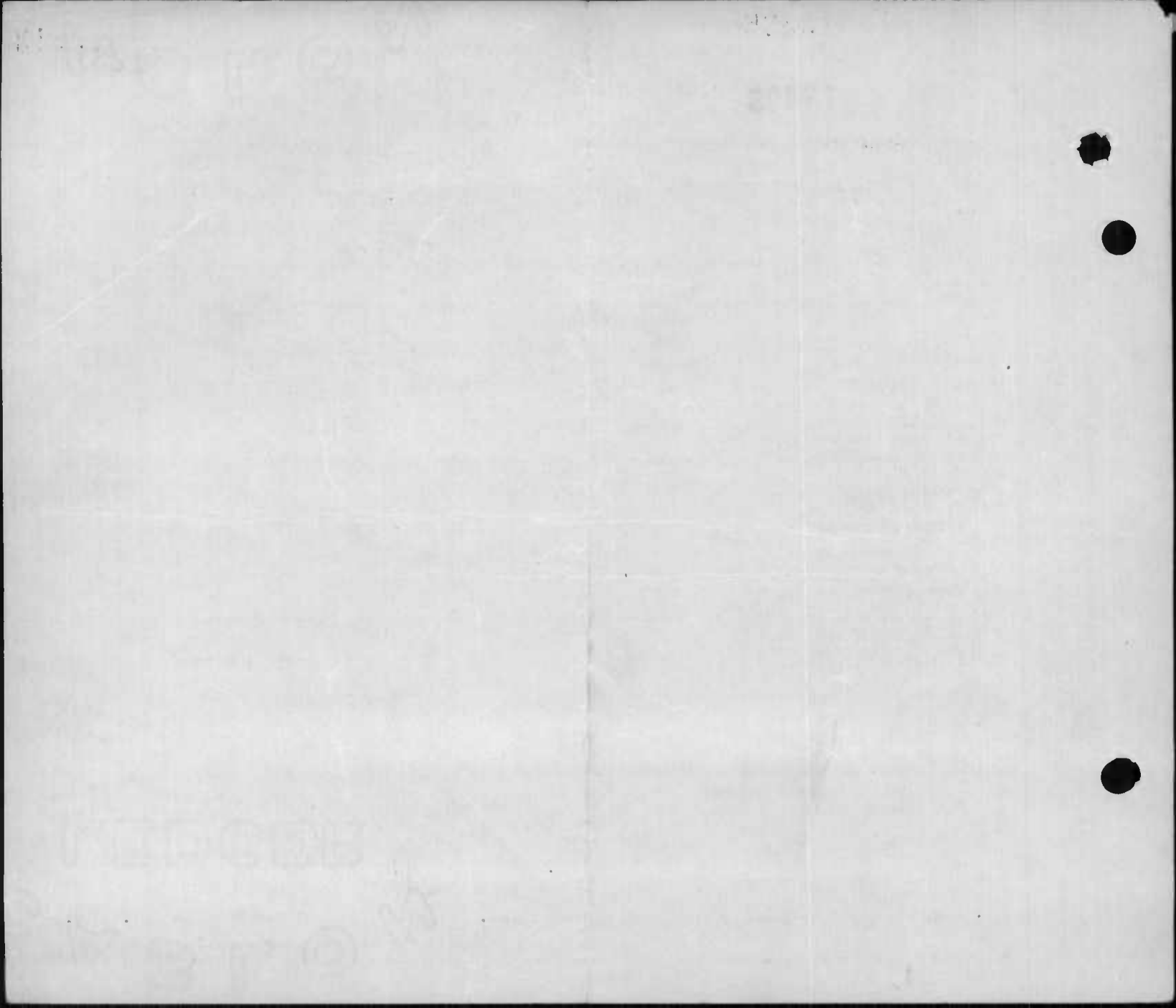
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Love Point Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Love Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lydia</u>	(Middle) <u>S-</u>	(Last) <u>Brenneman</u>
4. DATE OF DEATH	(Month) <u>Dec</u>	(Day) <u>26</u>	(Year) <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 21-1868</u>
9. AGE last birthday <u>87</u> yrs.	If under 1 year Months Days	If under 24 hrs Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Wm James Sinclair</u>
14. MOTHER'S MARRIAGE NAME <u>Samuel Cornelius Shannahan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY No. <u>✓</u>		17. INFORMANT AND ADDRESS <u>Mrs Adah M Lee - Love Pt Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>50 yrs</u>
(a) <u>Cardiac Asthma</u>		
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		
SIGNATURE <u>W. Henry Fisher - Dusherville Md Deputy Med Examin for 24 Co Md</u>		DATE SIGNED <u>12/26/58</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>12/29/58</u>	<u>Parkwood Cem.</u>
LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR	ADDRESS
<u>Baltimore Co., Md.</u>	<u>Wm. J. Tichenor House - Balt. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



12326

12313

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 253

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balt.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Chesler</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Balto. City md</u> <u>3v01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>2217 Cecil Ave</u> ✓	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Alvah</u>	(Middle) <u>James</u>	(Last) <u>Burk</u>	(Month) <u>Dec</u> (Day) <u>26</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH: <u>May 24-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>57</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country): <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Edmund Burk</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Mrs Edmund Burk - 2217 Cecil Ave Balt. md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Coronary occlusion with Angina Pectoris</u>	DUE TO	
Antecedent cause(s) (b) <u>Found dead in his auto.</u>	DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE W. Henry Fisher - Centerville md CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 12/26-55
 DEPUTY MEDICAL EXAMINER ☐ M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL CREMATION, REMOVAL (Specify): <u>Dec. 29</u>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>	LOCATION (City, town or county) (State) <u>Baltimore, Ind.</u>
DATE REC'D BY LOCAL REG. <u>Dec 26, 15</u>	REGISTRAR'S SIGNATURE <u>Elizabeth Hoxter</u>	24. FUNERAL DIRECTOR <u>Tickner Funeral Home</u>	ADDRESS <u>Baltimore, Ind.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 30 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

12314

12327

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>RICHARD</u>	(Middle)	(Last) <u>DUNN</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>69</u> yrs.
13. FATHER'S NAME <u>Horace Dunn</u>		14. MOTHER'S MAIDEN NAME <u>Hester Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS		12. CITIZEN OF WHAT COUNTRY?	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause		(a) <u>Acute Myocardial Infarction</u>	?
Antecedent cause(s)		(b) <u>Coronary Thrombosis</u>	?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Hypertensive-Arteriosclerotic (V.D.) Disease</u>	<u>Sev. Yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

21. ACCIDENT SUICIDE HOMICIDE		(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov., 1953, to Dec., 1955, that I last saw the deceased
alive on Dec 3, 1955, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

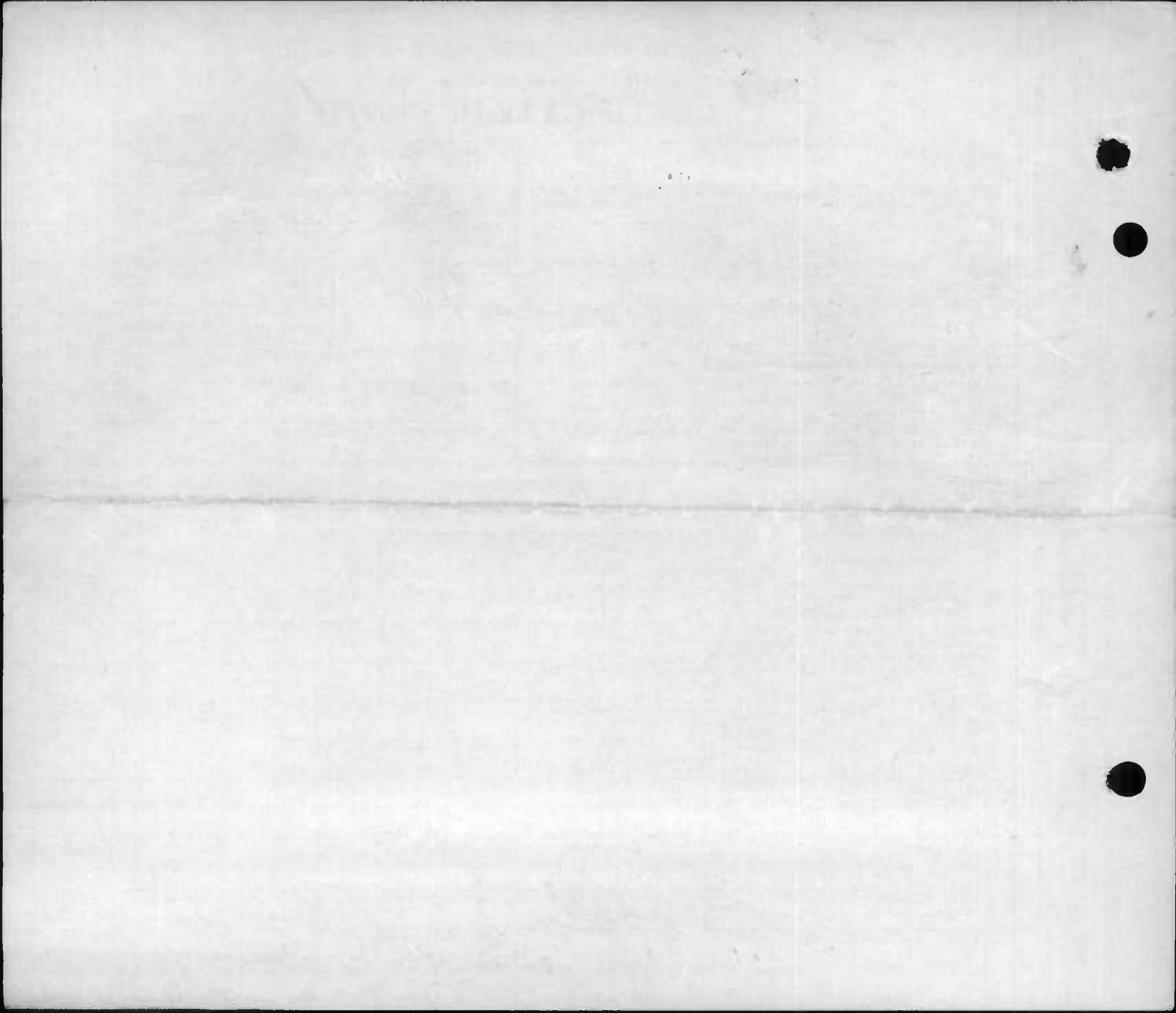
SIGNATURE _____ (Degree or title) ADDRESS _____ DATE SIGNED 12/6/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>12-8-55</u>	NAME OF CEMETERY OR CREMATORY <u>Chester</u>	LOCATION (City, town, or county) <u>Queen Anne's Md.</u>	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>[Signature]</u>	2. FUNERAL DIRECTOR <u>Severo A. Henry</u>		ADDRESS <u>802 Madison Ave Baltimore</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12328

CERTIFICATE OF DEATH

12315

Reg. Dist. No. 253

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Stevensville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stevensville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u>				STREET ADDRESS (If rural give location)		<u>/</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Charles</u> <u>Owen</u> <u>Ford</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec.</u> <u>8</u> <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Sept. 28-1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles A. Ford</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Ruth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Charles O. Ford--Stevensville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pleomorphic- cell carcinoma of left</u>						<u>about</u>	
ANTECEDENT CAUSE(S) DUE TO <u>bronchus</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>with metastases in both lungs</u>						<u>6 months</u>	
STATING UNDERLYING CAUSE LAST. DUE TO <u>and right axillary node</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>biopsy Oct. 27. 1955.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 8, 1955</u>, to <u>Dec. 8, 1955</u>; that I last saw the deceased alive on <u>Dec. 8, 1955</u>, and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Theodor Sattelmayer</u>		ADDRESS (Street, city, town, state) <u>Stevensville Md.</u>		DATE SIGNED <u>Dec. 9, 1955.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 11</u>		NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		LOCATION (City, town, or county) <u>Stevensville, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 14, 55</u>		REGISTRAR'S SIGNATURE <u>Elizabeth Hoyer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u>			

CERTIFICATE OF DEATH

1. DECEASED'S NAME (Print or Write)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEAREST RELATIVE

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF COURT

22. SIGNATURE OF JUDGE

23. SIGNATURE OF CLERK

24. SIGNATURE OF DECEASED

25. SIGNATURE OF NEAREST RELATIVE

26. SIGNATURE OF CLERGYMAN

27. SIGNATURE OF JUDGE

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF CORONER

30. SIGNATURE OF JURY

31. SIGNATURE OF COURT

32. SIGNATURE OF JUDGE

33. SIGNATURE OF CLERK

34. SIGNATURE OF DECEASED

35. SIGNATURE OF NEAREST RELATIVE

36. SIGNATURE OF CLERGYMAN

37. SIGNATURE OF JUDGE

38. SIGNATURE OF SHERIFF

39. SIGNATURE OF CORONER

40. SIGNATURE OF JURY

41. SIGNATURE OF COURT

42. SIGNATURE OF JUDGE

43. SIGNATURE OF CLERK

44. SIGNATURE OF DECEASED

45. SIGNATURE OF NEAREST RELATIVE

46. SIGNATURE OF CLERGYMAN

47. SIGNATURE OF JUDGE

48. SIGNATURE OF SHERIFF

49. SIGNATURE OF CORONER

50. SIGNATURE OF JURY

51. SIGNATURE OF COURT

52. SIGNATURE OF JUDGE

53. SIGNATURE OF CLERK

54. SIGNATURE OF DECEASED

55. SIGNATURE OF NEAREST RELATIVE

56. SIGNATURE OF CLERGYMAN

57. SIGNATURE OF JUDGE

58. SIGNATURE OF SHERIFF

59. SIGNATURE OF CORONER

60. SIGNATURE OF JURY

61. SIGNATURE OF COURT

BUREAU V. S.

DEC 15 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12316

12329 CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Pennsylvania</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Gretna</u>		<u>1 month</u>		TOWN <u>Washington</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 _____				<u>212 Linn Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harriet</u> (Middle) <u>Rose</u> (Last) <u>Joiner</u>				(Month) <u>12</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Widowed</u>	<u>11/11/1774/19/17</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>House</u>		<u>Quebec, Canada</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Peter Edward Butler</u>				<u>Mary Ann Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>None</u>		<u>None</u>		<u>Widelinean J. Widom, Gretna, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Fibrillation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerotic Cardiac</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Urologic Disease - Chronic Infection & Hydronephrosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 22, 1955</u> to <u>Dec 23, 1955</u> , that I last saw the deceased alive on <u>Dec 22, 1955</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. J. Butler</u>				DATE SIGNED <u>Dec 23, 1955</u>			
M.D. <u>C. J. Butler</u>				ADDRESS (Street, city, town, state) <u>Gretna, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 27-55</u>		<u>Washington Cemetery</u>		<u>Washington Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-24-55</u>		<u>Elaine Armstrong</u>		<u>W. J. Butler</u>		<u>Gretna, Md</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12330

CERTIFICATE OF DEATH

12567

Reg. Dist. No. 251

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Q. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Centerville</u> LENGTH OF STAY (in this place) <u>9 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Centerville - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Florence</u> (Middle) <u>Lane</u> (Last) <u>Lane</u>		4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>27</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>8-29-1868</u> 9. AGE last birthday <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Almonard Willie's</u>		14. MOTHER'S MARRIAGE NAME <u>Letitia Kirby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT AND ADDRESS <u>Rev. Lane - Stevensville, Ind.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>443X</u>		<u>Sec. mo.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>? yrs.</u>	
(a) <u>Cerebral Arteriosclerosis & Thrombosis</u>			
(b) <u>Hypertensive Arteriosclerosis C-V Disease</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
HOMICIDE INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 15, 1955</u> , to <u>Dec., 1955</u> , that I last saw the deceased alive on <u>Dec 16, 1955</u> , and that death occurred at <u>6 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Edwin D. Hays MD</u>		DATE SIGNED <u>12/27/55</u>	
(Degree or title)		ADDRESS <u>Queenstown Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>Dec. 31</u>	NAME OF CEMETERY OR CREMATORY <u>Centerville</u>	LOCATION (City, town, or county) (State) <u>Centerville Ind.</u>
DATE REC'D BY LOCAL REG. <u>12-27</u>	REGISTRAR'S SIGNATURE <u>Edgar R. Lane</u>	24. FUNERAL DIRECTOR ADDRESS <u>Edgar R. Lane - Church Hill Ind.</u>	

RECEIVED
JAN 9 1956
BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12331 CERTIFICATE OF DEATH

12568

Item 2, Film G191 1-13-56 et

Reg. Dist. No. 251

1. PLACE OF DEATH COUNTY <u>QUEEN ANNE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u> TOWN <u>SUDLERSVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EVERETT NURSING HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>QUEEN ANNE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u> TOWN <u>Church Hill</u> STREET ADDRESS (If rural give location) <u>---</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARY P. LUKENS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 30 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 11 - 1890</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WILLIAM CHANCE</u>				14. MOTHER'S MAIDEN NAME <u>BETSY WOODLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>MRS. CHESTER MASSEY - CHURCH HILL</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4221 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Sclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Smoking</u>							
19a. DATE OF OPERATION <u>Dec 20</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>---</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>---</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>Nov 20</u> , 19 <u>53</u> , to <u>Dec 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>55</u> , and that death occurred at <u>2 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>C. M. DeFotocette</u>				M. D. <u>Sudlersville</u>		DATE SIGNED <u>Dec 1/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>---</u>		DATE THEREOF <u>JAN 2</u>		NAME OF CEMETERY OR CREMATORY <u>LOMBARDY</u>		LOCATION (City, town, or county) (State) <u>WILM. DEL.</u>	
24. REC'D BY REGISTRAR DATE <u>1-1</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>EDGAR L. LANE</u>		ADDRESS <u>CHURCH HILL MD.</u>	

CERTIFICATE OF DEATH

1. Name of deceased

2. Date of death

3. Age of deceased

4. Sex

5. Race

6. Cause of death

7. Place of death

8. Date of burial

9. Name of physician

10. Name of undertaker

11. Name of funeral home

12. Name of cemetery

13. Name of church

14. Name of minister

15. Name of registrar

16. Name of witness

17. Name of witness

18. Name of witness

19. Name of witness

20. Name of witness

21. Name of witness

22. Name of witness

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25. Name of witness

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76. Name of witness

77. Name of witness

78. Name of witness

79. Name of witness

80. Name of witness

BUREAU V. S.

JAN 9 1936

RECEIVED

Handwritten signature

Handwritten signature

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12317

12332

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Katie</u>	(Middle) <u>Parks</u>	(Last) <u>Risley</u>
4. DATE OF DEATH	(Month) <u>Dec.</u>	(Day) <u>9</u>	(Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Aug. 30, 1894</u>
9. AGE last birthday <u>61</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Parks</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Fred Risley (husband) - Grasonville</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic Corruptive Heart Failure</u>		<u>7 yrs.</u>
Antecedent cause(s) (b) <u>Chronic Rheumatic Heart Disease</u>		<u>7 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1957, to Dec., 1955, that I last saw the deceased alive on Dec. 8, 1955, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Interment</u>	<u>Dec 11-1955</u>	<u>Grasonville</u>	<u>Grasonville</u>	<u>Q.A.</u>
DATE REC'D BY LOCAL REC	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>12/10/55</u>	<u>Helen M. Dedridge</u>	<u>John A. Williams</u>	<u>Grasonville</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 14 1955

BUREAU V. S.